Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HL100250	A. BUILDING: _____ B. WING _____	01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNS HOPKINS ALL CHILDREN'S HOSPITAL	501 SIXTH AVENUE SOUTH SAINT PETERSBURG, FL 33701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	INITIAL COMMENTS An unannounced complaint investigation (CCR# 2018017922) and risk management survey was conducted at Johns Hopkins All Children's Hospital located in St. Petersburg, FL on 1/7/2019 through 1/11/2019. License #4042. The survey was conducted in conjunction with Complaint CCR# 2019000375 (see Aspen QIPP11) and Complaint CCR# 2019000406 (see Aspen JPSM11). An Imminent Threat to patient safety was identified beginning on 9/20/2018 related to Quality Improvement System (refer to H204), Quality Improvement Data Assessment (refer to H206), Governing Body (refer to H208), and Organized Medical Staff (refer to H229).	H 000		
H 029	59A-3.254(4)(c)-(h) and (5) FAC 381.0261 PATIENT RIGHTS & CARE - Add'l Policy/Procedur 59A-3.254(4) (c) The right to information about patient rights as set forth in Section 381.026, F.S., and procedures for initiating, reviewing and resolving patient complaints; (d) The right to participate in the consideration of ethical issues that arise in the care of the patient; (e) The right to personal privacy and confidentiality of information including access to information contained in the patient's medical records as specified under Section 395.3025, F.S.; (f) The right of the patient's next of kin or designated representative to exercise rights on behalf of the patient; (g) The right to an itemized patient bill upon request as specified under Section 395.301, F.S.;	H 029		

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H 029	Continued From page 1 (h) The right to be free of restraints consistent with the rights of mentally ill persons or patients as provided in Section 394.459, F.S. (5) In addition to the provisions of this section, hospitals must comply with Section 381.026, F.S. 381.0261 Summary of patient's bill of rights; distribution; penalty.- (1) The Department of Health shall publish on its Internet website a summary of the Florida Patient's Bill of Rights and Responsibilities. In adopting and making available to patients the summary of the Florida Patient's Bill of Rights and Responsibilities, health care providers and health care facilities are not limited to the format in which the department publishes the summary. (2) Health care providers and health care facilities, if requested, shall inform patients of the address and telephone number of each state agency responsible for responding to patient complaints about a health care provider or health care facility's alleged noncompliance with state licensing requirements established pursuant to law. (3) Health care facilities shall adopt policies and procedures to ensure that inpatients are provided the opportunity during the course of admission to receive information regarding their rights and how to file complaints with the facility and appropriate state agencies. (4)(a) An administrative fine may be imposed by the Agency for Health Care Administration when any health care facility fails to make available to patients a summary of their rights, pursuant to s. 381.026 and this section. Initial nonwillful violations shall be subject to corrective action and shall not be subject to an administrative fine. The Agency for Health Care Administration may levy a fine against a health care facility of up to $5,000	H 029		

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H 029	Continued From page 2	H 029		

for nonwillful violations and up to $25,000 for intentional and willful violations. Each intentional and willful violation constitutes a separate violation and is subject to a separate fine.

381.026 Florida Patient's Bill of Rights and Responsibilities.-
(1) SHORT TITLE.-This section may be cited as the "Florida Patient's Bill of Rights and Responsibilities."
(2) DEFINITIONS.-As used in this section and s. 381.0261, the term:
(a) "Department" means the Department of Health.
(b) "Health care facility" means a facility licensed under chapter 395.
(c) "Health care provider" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, or a podiatric physician licensed under chapter 461.
(d) "Primary care provider" means a health care provider licensed under chapter 458, chapter 459, or chapter 464 who provides medical services to patients which are commonly provided without referral from another health care provider, including family and general practice, general pediatrics, and general internal medicine.
(e) "Responsible provider" means a health care provider who is primarily responsible for patient care in a health care facility or provider's office.
(4) RIGHTS OF PATIENTS.-Each health care facility or provider shall observe the following standards:
(a) Individual dignity.-
1. The individual dignity of a patient must be respected at all times and upon all occasions.
2. Every patient who is provided health care services retains certain rights to privacy, which must be respected without regard to the patient's

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H 029	Continued From page 3 economic status or source of payment for his or her care. The patient's rights to privacy must be respected to the extent consistent with providing adequate medical care to the patient and with the efficient administration of the health care facility or provider's office. However, this subparagraph does not preclude necessary and discreet discussion of a patient's case or examination by appropriate medical personnel. 3. A patient has the right to a prompt and reasonable response to a question or request. A health care facility shall respond in a reasonable manner to the request of a patient's health care provider for medical services to the patient. The health care facility shall also respond in a reasonable manner to the patient's request for other services customarily rendered by the health care facility to the extent such services do not require the approval of the patient's health care provider or are not inconsistent with the patient's treatment. 4. A patient in a health care facility has the right to retain and use personal clothing or possessions as space permits, unless for him or her to do so would infringe upon the right of another patient or is medically or programmatically contraindicated for documented medical, safety, or programmatic reasons. 5. A patient receiving care in a health care facility or in a provider's office has the right to bring any person of his or her choosing to the patient-accessible areas of the health care facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her health care provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility or	H 029		

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provider.
(b) Information.-
1. A patient has the right to know the name, function, and qualifications of each health care provider who is providing medical services to the patient. A patient may request such information from his or her responsible provider or the health care facility in which he or she is receiving medical services.
2. A patient in a health care facility has the right to know what patient support services are available in the facility.
3. A patient has the right to be given by his or her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information.
4. A patient has the right to refuse any treatment based on information required by this paragraph, except as otherwise provided by law. The responsible provider shall document any such refusal.
5. A patient in a health care facility has the right to know what facility rules and regulations apply to patient conduct.
6. A patient has the right to express grievances to a health care provider, a health care facility, or the appropriate state licensing agency regarding alleged violations of patients' rights. A patient has the right to know the health care provider's or health care facility's procedures for expressing a grievance.
7. A patient in a health care facility who does not speak English has the right to be provided an

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interpreter when receiving medical services if the facility has a person readily available who can interpret on behalf of the patient.
8. A health care provider or health care facility shall respect a patient's right to privacy and should refrain from making a written inquiry or asking questions concerning the ownership of a firearm or ammunition by the patient or by a family member of the patient, or the presence of a firearm in a private home or other domicile of the patient or a family member of the patient. Notwithstanding this provision, a health care provider or health care facility that in good faith believes that this information is relevant to the patient's medical care or safety, or safety of others, may make such a verbal or written inquiry.
9. A patient may decline to answer or provide any information regarding ownership of a firearm by the patient or a family member of the patient, or the presence of a firearm in the domicile of the patient or a family member of the patient. A patient's decision not to answer a question relating to the presence or ownership of a firearm does not alter existing law regarding a physician's authorization to choose his or her patients.
10. A health care provider or health care facility may not discriminate against a patient based solely upon the patient's exercise of the constitutional right to own and possess firearms or ammunition.
11. A health care provider or health care facility shall respect a patient's legal right to own or possess a firearm and should refrain from unnecessarily harassing a patient about firearm ownership during an examination.
(c) Financial information and disclosure.-
1. A patient has the right to be given, upon request, by the responsible provider, his or her designee, or a representative of the health care

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facility full information and necessary counseling on the availability of known financial resources for the patient's health care.
2. A health care provider or a health care facility shall, upon request, disclose to each patient who is eligible for Medicare, before treatment, whether the health care provider or the health care facility in which the patient is receiving medical services accepts assignment under Medicare reimbursement as payment in full for medical services and treatment rendered in the health care provider's office or health care facility.
3. A primary care provider may publish a schedule of charges for the medical services that the provider offers to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule must be posted in a conspicuous place in the reception area of the provider's office and must include, but is not limited to, the 50 services most frequently provided by the primary care provider. The schedule may group services by three price levels, listing services in each price level. The posting must be at least 15 square feet in size. A primary care provider who publishes and maintains a schedule of charges for medical services is exempt from the license fee requirements for a single period of renewal of a professional license under chapter 456 for that licensure term and is exempt from the continuing education requirements of chapter 456 and the rules implementing those requirements for a single 2-year period.
4. If a primary care provider publishes a schedule of charges pursuant to subparagraph 3., he or she must continually post it at all times for the duration of active licensure in this state when primary care services are provided to patients. If

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a primary care provider fails to post the schedule of charges in accordance with this subparagraph, the provider shall be required to pay any license fee and comply with any continuing education requirements for which an exemption was received.

5. A health care provider or a health care facility shall, upon request, furnish a person, before the provision of medical services, a reasonable estimate of charges for such services. The health care provider or the health care facility shall provide an uninsured person, before the provision of a planned nonemergency medical service, a reasonable estimate of charges for such service and information regarding the provider's or facility's discount or charity policies for which the uninsured person may be eligible. Such estimates by a primary care provider must be consistent with the schedule posted under subparagraph 3. Estimates shall, to the extent possible, be written in language comprehensible to an ordinary layperson. Such reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges based on changes in the patient's condition or treatment needs.

6. Each licensed facility, except a facility operating exclusively as a state facility, shall make available to the public on its website or by other electronic means a description of and a hyperlink to the health information that is disseminated by the agency pursuant to s. 408.05(3). The facility shall place a notice in the reception area that such information is available electronically and the website address. The licensed facility may indicate that the pricing information is based on a compilation of charges for the average patient and that each patient's

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statement or bill may vary from the average depending upon the severity of illness and individual resources consumed. The licensed facility may also indicate that the price of service is negotiable for eligible patients based upon the patient's ability to pay.
7. A patient has the right to receive a copy of an itemized statement or bill upon request. A patient has a right to be given an explanation of charges upon request.
(d) Access to health care.-
1. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
2. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide such treatment.
3. A patient has the right to access any mode of treatment that is, in his or her own judgment and the judgment of his or her health care practitioner, in the best interests of the patient, including complementary or alternative health care treatments, in accordance with the provisions of s. 456.41.
(e) Experimental research.-In addition to the provisions of s. 766.103, a patient has the right to know if medical treatment is for purposes of experimental research and to consent prior to participation in such experimental research. For any patient, regardless of ability to pay or source of payment for his or her care, participation must be a voluntary matter; and a patient has the right to refuse to participate. The patient's consent or refusal must be documented in the patient's care record.
(f) Patient's knowledge of rights and responsibilities.-In receiving health care, patients have the right to know what their rights and

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H 029	Continued From page 9 responsibilities are. (5) RESPONSIBILITIES OF PATIENTS.-Each patient of a health care provider or health care facility shall respect the health care provider's and health care facility's right to expect behavior on the part of patients which, considering the nature of their illness, is reasonable and responsible. Each patient shall observe the responsibilities described in the following summary. (6) SUMMARY OF RIGHTS AND RESPONSIBILITIES.-Any health care provider who treats a patient in an office or any health care facility licensed under chapter 395 that provides emergency services and care or outpatient services and care to a patient, or admits and treats a patient, shall adopt and make available to the patient, in writing, a statement of the rights and responsibilities of patients, including the following: SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows: A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy. A patient has the right to a prompt and reasonable response to questions and requests. A patient has the right to know who is providing	H 029		

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medical services and who is responsible for his or her care.
A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
A patient has the right to bring any person of his or her choosing to the patient-accessible areas of the health care facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her health care provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility or provider.
A patient has the right to know what rules and regulations apply to his or her conduct.
A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
A patient has the right to refuse any treatment, except as otherwise provided by law.
A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges

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explained.
A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
A patient is responsible for following the treatment plan recommended by the health care provider.
A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
A patient is responsible for his or her actions if he

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H 029	Continued From page 12 or she refuses treatment or does not follow the health care provider's instructions. A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible. A patient is responsible for following health care facility rules and regulations affecting patient care and conduct. This Statute or Rule is not met as evidenced by: Based on electronic patient medical record reviews, staff interview and review of the facility's policy and procedure, the facility failed to ensure the patient or patient's representative was provided information about patient rights as set forth in Section 381.026, F.S., for 6 of 6 patient medical records reviewed (#1, #2, #3, #4, #5, #6) of forty-two patients sampled. Findings include: On 1/9/2019 a total of 6 random medical records were reviewed, to include one closed record (#2) and five (#1, #3, #4, #5 and #6) open records. The facility was not able to demonstrate the patient or patient's representative received information related to patient rights prior to providing or discontinuing patient care for all 6 of the medical records reviewed. The review of the patient's records was completed with a facility representative to help navigate the electronic medical record. The record navigator was not able to locate this information during an interview on 1/9/2019 beginning at approximately 2:30 p.m., and first stated that nursing reviews this information with the patient. A review of the admitting documentation, completed by nursing, did not include information pertaining to patient rights. The Navigator, a Clinical Nurse Manager, then found out that admissions/registration	H 029		

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H 029	Continued From page 13 provides this information which is contained in an admission folder with facility specific information. There was no documentation to support that this information was provided to the patient or patient's representative. A review of the facility's policy and procedure, "Patient's Rights and Responsibilities, Management of," effective 3/6/2018 indicated "..... patients and families are provided Patient's Rights and Responsibilities information as required by law. In order to provide our patient/families with the most appropriate information, three versions of Patient's Rights and Responsibilities are available depending on who is provided services. The three versions available are for: Johns Hopkins All Children's Hospital, which includes hospital based service provided at the Outpatient Care Center; Johns Hopkins All Children's Home Care and All Children's Specialty Physician Clinics." The policy statement indicated, "All patients and families will be informed of their rights and responsibilities while receiving care and treatment though the services of Johns Hopkins All Children's. Patients and families will expect to carry out their responsibilities when accessing care and services at Johns Hopkins All Children's." The procedure indicates "A. The patient/legal guardian will be made aware of the Patient's Rights and Responsibilities upon admission and/or upon registration to Johns Hopkins All Children's. B. The Patient's Bill of Rights and Responsibilities are available to all patients/families as follows: 1. Hospital: Posted in the main Hospital and all Outpatient Care Centers. 2. Home Care: Provided upon admission. 3. Specialty Physician Clinical: Posted in clinic. C. Electronic versions of the Patient's Rights and Responsibilities are also	H 029		

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H 029	Continued From page 14 available to patients and families on the Johns Hopkins All Children's website at https://www.hopkinsallchildrens.org/home." The facility failed to identify the process and document that patient's rights information was provided to the patient or patient representative. A review of the facility's "Consent for Routine Diagnostic Procedures and Medical Treatment" was also conducted and failed to include information related to the provision of Patient Rights.	H 029		
H 168	59A-3.242(3)(h)1-6, FAC RESPIRATORY THERAPY - Patient Care (h) There shall be written policies and procedures specifying the scope and conduct of patient care rendered in the provision of respiratory care services. All policies and procedures must be approved by the physician director, reviewed annually, revised as necessary, dated to indicate the time of last review, and enforced. Respiratory care policies shall include the following: 1. Specification as to who may perform specific procedures and provide instruction, under what circumstances, and under what degree of supervision. 2. Assembly and sequential operation of equipment and accessories to implement therapeutic regimens. 3. Steps to be taken in the event of adverse reactions, and other emergencies. 4. Procurement, handling, storage and dispensing of therapeutic gases. 5. Infection control measures, including specifics as to changing and cleansing of equipment. 6. Administration of medications in accordance with the physician's order.	H 168		

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H 168	Continued From page 15 This Statute or Rule is not met as evidenced by: Based on observation and interview it was determined the facility failed to secure 9 of 10 portable oxygen e-cylinders within 2 wheeled carts to ensure a safe environment. Findings include: On 1/7/2019, day one of survey, a tour of the following patient care areas revealed six [6] of six [6] portable Oxygen E-Cylinders not secured within 2 wheeled carts as follows: - 3 of 3 unsecured in the Emergency Department - 1 of 1 unsecured in NICU [Neonatal Intensive Care Unit] South 6th floor - 1 of 1 unsecured in NICU [Neonatal Intensive Care Unit] North 6th floor - 1 of 1 unsecured in PICU [Pediatric Intensive Care Unit] 5th floor On 01/09/2019, day three of survey, additional oxygen e-cylinders were found to be unsecured within 2 wheeled carts as follows: - 1 of 1 unsecured in procedure room 2351 - 1 of 2 unsecured in clean utility room 1154, also room not identified as a storage room for oxidizing gas. - 1 of 1 unsecured in patient room An interview was conducted during the tour with the Director of Pediatric Emergency Services, Trauma, Lifeline, Nursing Supervision, Workforce Management and Respiratory Therapy and confirmed the findings.	H 168		
H 190	59A-3.270(3) FAC; 395.3025(6) FS HEALTH INFORMATION MGMT - Medical Records	H 190		

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H 190	Continued From page 16 59A-3.270(3) Each hospital shall maintain a current and complete medical record for every patient seeking care or service. The medical record shall contain information required for completion of birth, death and still birth certificates, and shall, contain the following information: (a) Identification data; (b) Chief complaint or reason for seeking care; (c) Present illness; (d) Personal medical history; (e) Family medical history; (f) Physical examination report; (g) Provisional and pre-operative diagnosis; (h) Clinical laboratory reports; (i) Radiology, diagnostic imaging, and ancillary testing reports; (j) Consultation reports; (k) Medical and surgical treatment notes and reports; (l) Evidence of appropriate informed consent; (m) Evidence of medication and dosage administered; (n) A copy of the Patient Care Record, in accordance with subsection 64J-1.001(18), F.A.C., if the patient was delivered to the hospital by ambulance; (o) Tissue reports; (p) Physician, ARNP, PA and nurse progress notes; (q) Principal diagnosis, secondary diagnoses and procedures when applicable; (r) Discharge summary; (s) Appropriate social work services reports, if provided; (t) Autopsy findings when performed; (u) Individualized treatment plan; (v) Clinical assessment of the patients needs; (w) Certifications of transfer of the patient	H 190		

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H 190	Continued From page 17 between hospitals as specified by Rule 59A-3.255, F.A.C.; and (x) Routine Inquiry Form regarding request for organ donation in the event of the death of the patient. 395.3025(6) Patient records shall contain information required for completion of birth, death, and fetal death certificates. This Statute or Rule is not met as evidenced by: Based on review of the medical record, review of facility policy, and staff interview it was determined the facility failed to ensure the medical record contained evidence of appropriately executed informed consent form for one (#35) of forty-two sampled patients. Findings include: Review of the facility policy, "Informed Consent for Medical/Surgical Procedures," with an effective date of 4/2/2018, stated it is the practitioner's responsibility to obtain informed consent from the patient/parent(s)/legal guardian(s) prior to providing care or treatment to patients, except in medical emergencies, and to provide adequate information so that the patient/parent(s)/legal guardian(s) may make educated and informed decisions about proposed care. The policy stated telephone consent may be obtained from a person who has legal authority to consent but who is unable to present in person. The policy stated abbreviations may not be used to describe the intervention on the consent form. Review of the medical record for patient #35 revealed the patient, a , was admitted	H 190		

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H 190	Continued From page 18 on . Review of the record revealed informed consent, dated at 3:11 pm, for to in There was no explanation of the abbreviations documented on the informed consent. Review of the informed consent, dated at 3:11 pm, revealed the documentation written for relation to patient was "phone consent." There was no documentation from whom the consent was obtained. Interview with the Director of Accreditation & Survey Readiness on 1/10/2019 at approximately 2:30 pm confirmed the above findings.	H 190		
H 204	59A-3.271(1), FAC QUALITY IMPROVEMENT - System (1) General Provisions. Each hospital shall have a planned, systematic, hospital wide approach to the assessment, and improvement of its performance to enhance and improve the quality of health care provided to the public. (a) Such a system shall be based on the mission and plans of the organization, the needs and expectations of the patients and staff, up-to-date sources of information, and the performance of the processes and their outcomes. (b) Each system for quality improvement, which shall include utilization review, must be defined in writing, approved by the governing board, and enforced, and shall include: 1. A written delineation of responsibilities for key staff; 2. A policy for all privileged staff, whereby staff members do not initially review their own cases for quality improvement program purposes; 3. A confidentiality policy;	H 204		

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H 204	Continued From page 19 4. Written, measurable criteria and norms; 5. A description of the methods used for identifying problems; 6. A description of the methods used for assessing problems, determining priorities for investigation, and resolving problems; 7. A description of the methods for monitoring activities to assure that desired results are achieved and sustained; and 8. Documentation of the activities and results of the program. This Statute or Rule is not met as evidenced by: Based on document review and staff interview it was determined the facility failed to ensure objective quality indicator data related to medical care was collected, tracked, trended, and analyzed across the organization to facilitate the process of providing quality patient care and improving patient safety. As a result of these failures, an Imminent Threat to patient safety was identified beginning on 9/20/2018. Findings include: The Quality and Patient Safety Plan (the Plan) FY (fiscal year) 2019, approved September 20, 2018 was signed by the Patient Safety Officer and the Chair, Board Quality and Patient Safety Committee. The Plan indicated the Patient Safety and Quality Council reported to the Board of Trustees through the Board Quality and Patient Safety Committee. The Plan indicated several Medical Staff committees received or provided reports regarding patient safety and and quality. The Plan included documentation the Clinical Practice council oversees the prioritization, development, and deployment of clinical guidelines. Each department, program, and institute conducts quality improvement and safety	H 204		

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H 204	Continued From page 20 initiatives that are aligned with the strategic priorities of the organization and/or the population served by that department, program, or institute. Review of the facility's current written agreement with the OPO (organ procurement organization), signed with the most recent addendum on 1/23/2018, revealed section G. Activity Data Review, Reporting and Quality Assessment (QA) and Improvement (QI) stated "G.1 At least annually, the Foundation shall provide Donor Hospital specific data with the appropriate Donor Hospital personnel for the purposes of quality assessment (QA) and improvement (QI), process evaluation, and to analyze outcomes of potential referral/donor situations, allowing for a collaborative plan of corrective action when indicated." Review of the facility's Board Quality and Patient Safety Committee meeting minutes revealed the last meeting in which specific data was provided was 1/19/2017. Review of requested documentation revealed the OPO provided data for calendar years 2017 and 2018. There was no evidence the data was provided to the facility's Board Quality and Patient Safety Committee for integration into the hospital's QAPI (Quality Assurance Performance Improvement) program. An interview was conducted with the Interim Vice President of Medical Affairs on 1/8/19 regarding the oversight of medical quality of care. The Vice President indicated the Medical Quality of Care Committee would review individual cases that were brought to their attention, but they had no historical data related to that particular problem or that particular physician. He indicated no data was collected or reported as a result of the Committee's review of any individual case.	H 204		

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H 204	Continued From page 21 An interview was conducted with the Interim Chief Executive Officer (CEO), the Senior Vice President Patient Safety Officer, the Interim Vice President of Medical Affairs, the Senior Director of Patient Safety and Quality/Interim Patient Safety Officer, the General Counsel, the Chief Operating Officer, the Regulatory Compliance Manager, the Vice President for Quality and Risk Management Johns Hopkins and other interested parties on 1/11/19 at 9:30 a.m. The Senior Director of Patient Safety and Quality confirmed that each clinical division and department develops their own criteria and quality indicators, and performs their own investigations of any events. The Senior Director indicated there is no organization wide, integrated assessment based on the tracking, trending, and analysis of objective data used to identify high frequency or high acuity concerns related to the overall quality of care and patient safety provided by the hospital. She indicated the facility has no historical data on objective indicators of quality of care that have been tracked, trended, and analyzed such as unplanned returns to surgery, patient deaths, or morbidity and mortality statistics by physician. The CEO confirmed the findings.	H 204		
H 206	59A-3.271(3), FAC QUALITY IMPROVEMENT - Data Assessment Process (3) Each hospital shall have a process to assess data collected to determine: (a) The level and performance of existing activities and procedures, (b) Priorities for improvement, and (c) Actions to improve performance.	H 206		

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H 206	Continued From page 22 This Statute or Rule is not met as evidenced by: Based on document review and staff interview it was determined the facility failed to ensure objective quality indicator data related to medical care was collected, tracked, trended, and analyzed across the organization to facilitate the process of providing quality patient care and improving patient safety. As a result of these failures, an Imminent Threat to patient safety was identified beginning on 9/20/2018. Findings include: The Quality and Patient Safety Plan (the Plan) FY (fiscal year) 2019, approved September 20, 2018 was signed by the Patient Safety Officer and the Chair, Board Quality and Patient Safety Committee. The Plan indicated the Patient Safety and Quality Council reported to the Board of Trustees through the Board Quality and Patient Safety Committee. The plan indicated several Medical Staff committees received or provided reports regarding patient safety and quality. The plan included documentation that the Clinical Practice Council oversees the prioritization, development and deployment of clinical guidelines. Each department, program, and institute conducts quality improvement and safety initiatives that are aligned with the strategic priorities of the organization and/or the population served by that department, program, or institute. Review of the facility's current written agreement with the OPO (organ procurement organization) revealed section G. Activity Data Review, Reporting and Quality Assessment (QA) and Improvement (QI) stated "G.1 At least annually, the Foundation shall provide Donor Hospital specific data with the appropriate Donor Hospital	H 206		

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H 206	Continued From page 23 personnel for the purposes of quality assessment (QA) and improvement (QI), process evaluation, and to analyze outcomes of potential referral/donor situations, allowing for a collaborative plan of corrective action when indicated." Review of the facility's Board Quality and Patient Safety Committee meeting minutes revealed the last meeting in which specific data was provided was 1/19/2017. Review of requested documentation revealed the OPO provided data for calendar years 2017 and 2018. There was no evidence the data was provided to the facility's Board Quality and Patient Safety Committee for integration into the hospital's QAPI program. An interview was conducted with the Interim Vice President of Medical Affairs on 1/8/19 regarding the oversight of medical quality of care. The Vice President indicated the Medical Quality of Care Committee would review individual cases that were brought to their attention, but they had no historical data related to that particular problem or that particular physician. He indicated no data was collected or reported as a result of the Committee's review of any individual case. An interview was conducted with the Interim Chief Executive Officer (CEO), the Senior Vice President Patient Safety Officer, the Interim Vice President of Medical Affairs, the Senior Director of Patient Safety and Quality/Interim Patient Safety Officer, the General Counsel, the Chief Operating Officer, the Regulatory Compliance Manager, the Vice President for Quality and Risk Management Johns Hopkins and other interested parties on 1/11/19 at 9:30 a.m. The Senior Director of Patient Safety and Quality confirmed that each clinical division and department	H 206		

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H 206	Continued From page 24 develops their own criteria and quality indicators, and performs their own investigations of any events. The Senior Director indicated there is no organization wide, integrated assessment based on the tracking, trending, and analysis of objective data used to identify high frequency or high acuity concerns related to the overall quality of care and patient safety provided by the hospital. She indicated the facility has no historical data on objective indicators of quality of care that have been tracked, trended, and analyzed such as unplanned returns to surgery, patient deaths, or morbidity and mortality statistics by physician. The CEO confirmed the findings.	H 206		
H 208	59A-3.272(1), FAC GOVERNING BODY The licensee shall have a governing body responsible for the conduct of the hospital as a functioning institution This Statute or Rule is not met as evidenced by: Based on document review and staff interview it was determined the Governing Body failed to ensure the management of the organization was structured to ensure the effective implementation of a data-driven quality improvement organization that measurably improved the facility's demonstrated ability to provide quality patient care and improve patient safety. As a result of these failures, an Imminent Threat to patient safety was identified beginning on 9/20/2018. Findings include: The Quality and Patient Safety Plan dated 9/20/18 indicated that the governing body was responsible for assuring that the Quality and	H 208		

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H 208	Continued From page 25 Patient Safety Plan was effective and in compliance with regulatory requirements. The organizational chart included in the plan displayed the committees for Environment of Care, Continuous Regulatory Readiness, Quality Council, Safety Coaches, Infection Prevention/Antimicrobial Stewardship, and High Value Care reported to the Patient Safety and Quality Council. The Patient Safety and Quality Council received input from the Ambulatory Networks Council, the Advocacy Council, the Clinical Practice Council, the Research Council, the Education Counsel, the Cultures and Engagement Council, the Medical Staff Committees, the Johns Hopkins Medical Pediatric Quality Group, and the Johns Hopkins Quality, Safety, and Service Executive Committee. The Patient Safety and Quality Council reported to the Board Quality and Patient Safety Committee, who in turn reported to the Board of Trustees. The Risk Management department was not indicated on the organizational chart included included in the Quality and Safety Plan. Nothing in the plan addressed the manner in which objective data would be tracked, trended, and analyzed across the organization as a whole in order to identify areas of concern, or monitor the effectiveness of quality improvement projects or plans of correction. The Johns Hopkins All Children's Hospital Functional Organizational Structure dated 1/3/18 displayed the Risk Management and Insurance Department as the last item in the lower right hand corner of the chart, reporting to Legal Affairs, that in turn reported to the Vice Dean/Physician in Chief. There was no evidence of any lines of communication or accountability between the Risk Management Department and	H 208		

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H 208	Continued From page 26 any of the 17 committees, councils, and departments shown on the organizational chart as being responsible for the prioritization, development and deployment of clinical guidelines. The plan defined the purpose, objectives, membership, meeting frequency, and reporting structures of the Board Quality and Patient Safety Council, Patient Safety Council, the Quality Sub-Council, and Safety Coaches. The plan defined the roles and responsibilities of the Medical Staff, Senior Leadership, Patient Safety Officer, Senior Director, Institute, Department and Service-line Directors, and Employees. The responsibilities of the Medical Staff were presented as Department Chairpersons shall be accountable for their assigned divisions and sections appropriate, quality, and safe patient care services. The plan did not include any evidence that the selection of indicators, quality improvement projects, or the development of criteria were based on any review of the tracking and trending of objective data that identified measurable concerns or issues that were high frequency or high acuity. An interview was conducted with the Interim Chief Executive Officer (CEO), the Senior Vice President Patient Safety Officer, the Interim Vice President of Medical Affairs, the Senior Director of Patient Safety and Quality/Interim Patient Safety Officer, the General Counsel, the Chief Operating Officer, the Regulatory Compliance Manager, the Vice President for Quality and Risk Management Johns Hopkins and other interested parties on 1/11/19 at 9:30 a.m. The Senior Director of Patient Safety and Quality confirmed	H 208		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 208	Continued From page 27 that each clinical division and department develops their own criteria and quality indicators, and performs their own investigations of any events. Each clinical division and department develops their own action plans, implements, and evaluates the plans for effectiveness, and reports whatever information they determine is relevant or necessary through the channels shown on the organizational chart in the Quality and Patient Safety Plan. The Senior Director indicated there is no organization wide, integrated assessment based on the tracking, trending, and analysis of objective data used to identify high frequency or high acuity concerns related to the overall quality of care and patient safety provided by the hospital. The Senior Director indicated she did not have access to any Risk Management reports or data collection in the 15 months she has been in her position at the facility. She indicated the facility has no historical data on objective indicators of quality of care that has been tracked, trended, and analyzed such as unplanned returns to surgery, patient deaths, or morbidity and mortality statistics by physician. The CEO confirmed the findings.	H 208		
H 229	59A-3.275(1), FAC ORGANIZED MEDICAL STAFF (1) Each hospital shall have an organized medical staff organized under written by-laws approved by the governing body and responsible to the governing body of the hospital for the quality of all health care provided to patients in the facility and for the ethical and professional practices of its members. This Statute or Rule is not met as evidenced by: Based on document review and staff interviews, it	H 229		

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H 229	Continued From page 28 was determined the Governing Body failed to develop and implement an effective organizational structure to permit the timely, objective, and on-going assessment of the competence and quality of care of the medical staff. As a result of these failures, an Imminent Threat to patient safety was identified beginning on 9/20/2018. Findings include: The Medical Staff Bylaws, effective date 9/20/18, indicated each medical staff Department and Division shall be responsible for developing criteria to assure the Medical Staff and the Board that patients will receive quality and safe care. The professional criteria shall at least pertain to evidence of relevant training or experience, current competence, and ability to perform the privileges requested (Page 18, section 6.5). The Medical Executive Committee (MEC) is empowered to act on behalf of the Medical Staff. The MEC responsibilities included: Provide a liaison between the medical Staff and the CEO, make recommendations to the Board regarding all matters relating to [medical staff] appointments, reappointments, and clinical privileges. The Bylaws indicated the MEC was responsible for the Medical Staff performance-improvement activities and establish a mechanism designed to conduct, evaluate and revise such activities. The review of John's Hopkins All Children's Hospital Functional Organizational Structure dated 1/3/19 revealed 10 medical staff departments lead by physicians (Interim VP of Medical Affairs, Assistant Dean Population Health, Department of Anesthesia, Department of Surgery, Department of Pediatrics, Cancer	H 229		

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H 229	Continued From page 29	H 229		

Institute, Heart Institute, IFBR (Institute of Fundamental Biomedical Research) Institute, MFN (Maternal, Fetal, Neonatal) Institute, and the IBPS (Institute for Brain Protection Services) Institute) reported directly to the Vice Dean/Physician in Chief, who in turn reported to the President. There was no evidence of the Medical Executive Committee or its relationship to the Medical Staff, the President or the Board of Trustees. Neither the Medical Executive Committee nor the Board of Trustees were represented on the organizational chart.

The review of Johns Hopkins All Children's Hospital Medical Staff Leadership 2019 organizational chart dated 1/3/19 revealed the physician division heads for the 20 medical sub-specialties reported to the Chairman and Vice Chairman of the Department of Pediatric Medicine. The physician division heads for the 12 surgical sub-specialties reported to the Interim Chair for the Department of Surgery. The Department of Pediatric Medicine and the Department of Surgery reported to the Chief of Staff, the Vice Chief of Staff and the Secretary/Treasurer, who in turn reported to the Executive Committee. The Executive Committee and the President reported to the Board of Trustees.

The Johns Hopkins All Children's Hospital Functional Organizational Structure dated 1/3/18 failed to provide evidence of any lines of communication or accountability between any of the 17 committees, councils and departments shown on the organizational chart as being responsible for the prioritization, development and deployment of clinical guidelines.

The Senior Director of Patient Safety and Quality

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H 229	Continued From page 30 confirmed that each clinical division and department develops their own criteria and quality indicators, and performs their own investigations of any events. Each clinical division and department develops their own action plans, implements and evaluates the plans for effectiveness, and reports whatever information they determine is relevant or necessary through the channels shown on the organizational chart in the Quality and Patient Safety Plan. The Senior Director indicated there is no organization wide, integrated assessment based on the tracking, trending, and analysis of objective data used to monitor the overall quality of care and patient safety provided by the hospital. She indicated the facility has no historical data on objective indicators of quality of care that has been tracked, trended, and analyzed such as unplanned returns to surgery, patient deaths, or morbidity and mortality statistics by physician. The CEO confirmed the finding the Medical Staff has not been effectively accountable to the governing body.	H 229		
H 410	395.0197(1)(e) FS; 59A-10.0055(2)(a-b) RM Prog - Incident Reporting System 395.0197(1)(e) The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report adverse incidents to the risk manager, or to his or her designee, within 3 business days after their occurrence. 59A-10.0055. (2) INCIDENT REPORTS. The incident reporting system shall include the prompt, within 3 calendar	H 410		

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H 410	Continued From page 31 days, reporting of incidents to the risk manager, or his designee. Reports shall be on a form developed by the facility for the purpose and shall contain at least the following information: (a) The patient's name, locating information, admission diagnosis, admission date, age and sex; (b) A clear and concise description of the incident including time, date, exact location; and elements as needed for the annual report based on ICD-9-CM; This Statute or Rule is not met as evidenced by: Based on facility record review, policy review, and interview it was determined that the facility failed to ensure all incidents are reported to the Risk Manager or their designee within 3 business days for one (Incident # 9) out of fifteen incident reports reviewed. Findings include: A review of 15 incident reports with the Risk Manager revealed one of fifteen failed to be reported to Risk Management within 3 business days. Incident #9 occurred on and not reported to Risk Management until No documentation was provided of a reason for delay or follow-up training. An interview with the Risk Manager on 1/10/2019 at 10:00 a.m. confirmed the above findings.	H 410		
H 412	59A-10.0055(2)(c)-(e), FAC INCIDENT REPORTING SYSTEM - Reports (c) Whether or not a physician was called; and if so, a brief statement of said physician's recommendations as to medical treatment, if any;	H 412		

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H 412	Continued From page 32 (d) A listing of all persons then known to be involved directly in the incident, including witnesses, along with locating information for each; (e) The name, signature and position of the person completing the reports, along with date and time that the report was completed This Statute or Rule is not met as evidenced by: Based on facility record review, and interview it was determined the facility failed to notify the physician for one (Incident #1) of fifteen incidents reviewed. Findings include: A review of fifteen incidents on 01/10/2019 revealed on incident #1 incorrect were administered. The review failed to document a physician notification. An interview with the Risk Manager on 1/10/2019 at 10:00 a.m. confirmed the findings.	H 412		

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K 000	Initial Comments An unannounced Fire & Life Safety re-licensure survey was conducted on 1/7/2019 through 1/11/2019 at Johns Hopkins All Children's Hospital, state license: 4042, a hospital in St Petersburg, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2015 edition) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69A-3, F.A.C. 69A-53, F.A.C. 59A-3, Florida Statutes (F.S.) 395.001 395.3041 Part I, and (F.S.) 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2015 edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following is a description of the deficiencies found at the time of the visit.	K 000		
K 325	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30	K 325		

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K 325	Continued From page 1 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This STANDARD is not met as evidenced by: Based on observations and interview with the Director of Facilities during the facility tour, the facility failed to properly install ABHR (Alcohol Based Hand Rub) dispensers. Findings include: During the facility tour with the Director of Facilities on 1/9/2019 between the hours of 9:15 a.m. and 3:00 p.m., it was observed that ABHR (Alcohol Based Hand Rub) dispensers were installed above ignition sources located in the following areas of the Neonatal Intensive Care Unit (NICU): 1) Rooms 7731, 6478, 6430 2) In corridor by room 5116 An interview conducted with the Director of Facilities concurrent with the observations confirmed the findings. per NFPA 101 (2015 Edition) 19.4.3(8)a,b,c	K 325		
K 345	NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		

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K 345	Continued From page 2 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.5, 9.6.7, 9.6.8, and NFPA 70, NFPA 72 This STANDARD is not met as evidenced by: Based on document review and interview the facility failed to maintain the Fire Alarm System. Maintaining the Fire Alarm System ensures proper operation and lessens the chance of a delayed alarm activation under hazardous conditions. Findings include: During document review with the Director of Facilities on 1/7/2019 at 10:15 a.m., an inspection completed on 3/07/2018 revealed 44 duct detectors failed to have the differential pressure testing completed due to access restriction. The facility has failed to take corrective action to test the 44 duct detectors for the annual differential pressure test. An interview was conducted with the director of facilities concurrent with the observations and confirmed the findings. per NFPA 101 (2015 Edition) 19.3.4.1, 9.6 per NFPA 72 (2013 Edition) 14.4.3.2(17)g(5)	K 345		

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K 353	Continued From page 3	K 353		
K 353	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on document review and interview with the Director of Facilities, it was revealed that the facility failed to maintain required inspections on the sprinkler system. Findings include: 1) During document review on 1/7/2019 at 10:15 a.m., the facility failed to provide evidence of the current annual (fire service) backflow inspection. The tag on the backflow indicates it was last inspected on 8/2017. An interview was conducted with the Director of Facilities concurrent with the observations and confirmed the findings.	K 353		

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K 353	Continued From page 4 Per NFPA 101 (2015 Edition) 19.3.5, 9.7 per NFPA 25 (2014 Edition) 13.6 through 13.6.3 2) During the facility tour with the Director of Facilities on 1/8/2019 through 1/10/2019 between the hours of 9:15 a.m. and 3:00 p.m., it was found that: 1) Mixed sprinkler types of standard and quick response found in sterile processing located in the basement. 2) Corroded sprinkler found in dietary kitchen above automated dish washer. 3) Corroded sprinkler found in mail/copy room 0222 (1 of 19). 4) 1 of 4 corroded sprinklers found in the decontamination room located on the 1st floor in the Emergency department. 5) Loaded sprinklers found throughout facility. The facility shall perform an inspection of and document ALL sprinklers installed throughout the facility for evidence of loading, painted, and corrosion and make repairs as required by NFPA 25. An interview was conducted with the Director of Facilities concurrent with the observations and confirmed the findings. Per NFPA 101 (2015 Edition) 19.3.5, 9.7 per NFPA 25 (2014 Edition) 5.2.1.1.1, 5.2.1.1.2(1-6) per NFPA 13 (2013 Edition) 8.3.3.2	K 353		
K 907	NFPA 99 Gas and Vacuum Piped Systems - Maintenance Pr Gas and Vacuum Piped Systems - Maintenance Program	K 907		

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K 907	Continued From page 5 Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on observations and interview with the Director of Facilities, the facility failed to maintain the medical gas system in accordance with NFPA 99 (2012 edition). Improper use and management of medical gas systems could result in failure of the system to perform as designed. Findings include: During the life safety survey conducted on 1/7/2019 through 1/11/2019, inspection of the anesthesia carts Waste Anesthetic Gas Disposal (WAGD) lines (purple) were connected to vacuum lines (white) with a t-connector in the following areas: 1) CT scan room 1351 anesthesia cart. 2) Procedure room 2351 anesthesia cart. An interview was conducted with the Director of Facilities concurrent with the observations and confirmed the findings.	K 907		

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K 907	Continued From page 6 per NFPA 99 (2012 Edition) 5.1.5.16.1(1)	K 907		
K 923	NFPA 99 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are	K 923		

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K 923	Continued From page 7 marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observations and interview with the Director of Facilities during the facility tour, the facility failed to maintain proper storage and handling of oxygen cylinders. Findings include: During the facility tour with the Director of Facilities on 1/8/2019 through 1/10/2019 between the hours of 9:15 a.m. and 3:00 p.m., it was found that: 1) E-size oxygen cylinders were found unsecured in wheeled carts. Facility failed to use stays/set screws to secure cylinders in the following areas: a) Procedure room 2351 (1 of 1) b) Clean utility room 1154 (1 of 2), room not identified as a storage room for oxidizing gas. c) Resident room (1 of 1) 2) Facility failed to display NFPA 99 required signs for storage of oxidizing gas(es) in all medical gas storage rooms. 3) C-wing medical gas storage room contained 15 E-size oxygen cylinders with combustibles stored within 5 feet of oxidizing gas(es). An interview was conducted with the Director of Facilities concurrent with the observations and confirmed the findings. Per NFPA 99 (2012 Edition) 11.3.2.2(2), 11.3.4.1, 11.3.4.2, 11.4.3.1.1	K 923		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HL100250	A. BUILDING: _____ B. WING _____	01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNS HOPKINS ALL CHILDREN'S HOSPITAL	501 SIXTH AVENUE SOUTH SAINT PETERSBURG, FL 33701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	INITIAL COMMENTS An unannounced complaint investigation, CCR# 2019000375, was conducted at Johns Hopkins All Children's Hospital located in St. Petersburg, FL on 1/09/2019 through 1/11/2019, license #4042. The survey was conducted in conjunction with a Risk Management Survey (see Aspen TTVR11), Complaint CCR#2018017922/FL00098488 (see Aspen KR5L11/TTVR11) and Complaint CCR# 2019000406/FL00099102 (see Aspen JPSM11/3RFT11). There were no deficiencies identified at the time of the survey related to CCR# 2019000375.	H 000		